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Conference Abstract

Management of locally advanced prostate cancer before the era of abiraterone/enzalutamide: A case study from India[☆]

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This is a case presentation of a 57-year-old male patient treated for prostate cancer before the advent of novel agents such as abiraterone and enzalutamide. The patient presented with obstructive lower urinary tract symptoms in the year 2000. Digital rectal examination revealed hard enlarged prostate with mobile rectal mucosa. Prostate-specific antigen (PSA) was 36 ng/mL, transrectal ultrasound guided biopsy revealed S/O adenocarcinoma and a high Gleason score (4+3), CT scan of the pelvis found mild prostatomegaly with no LAP, and bone scan revealed no metastases. Radical prostatectomy was initially planned but was aborted when

further examination revealed two enlarged lymph nodes and the frozen section was negative for malignancy. Despite being given hormonal agents and chemotherapy, his disease progressed, and the patient died in 2010 (Fig. 1).

The treatment landscape for castration-resistant prostate cancer (CRPC) has evolved dramatically, particularly over the last decade. Prior to the era of novel agents, patients were treated with high dose secondary hormonal agents such as ketoconazole, aminoglutethimide, corticosteroids and antioestrogens such as fosfesterol oestrogen (Honvan[®]). Estramustine phosphate was also used with modest effect.¹ PCAPES, a Chinese herbal medicine was also very popular back then.

In one study by Williams et al, oestrogen therapy resulted in 92% subjective improvement.² Among patients who were hormone refractory, 11% had a decline in PSA levels and 33% had a subjective response. In Citrin et al,³ 3 out of 18 patients on oestrogen had more

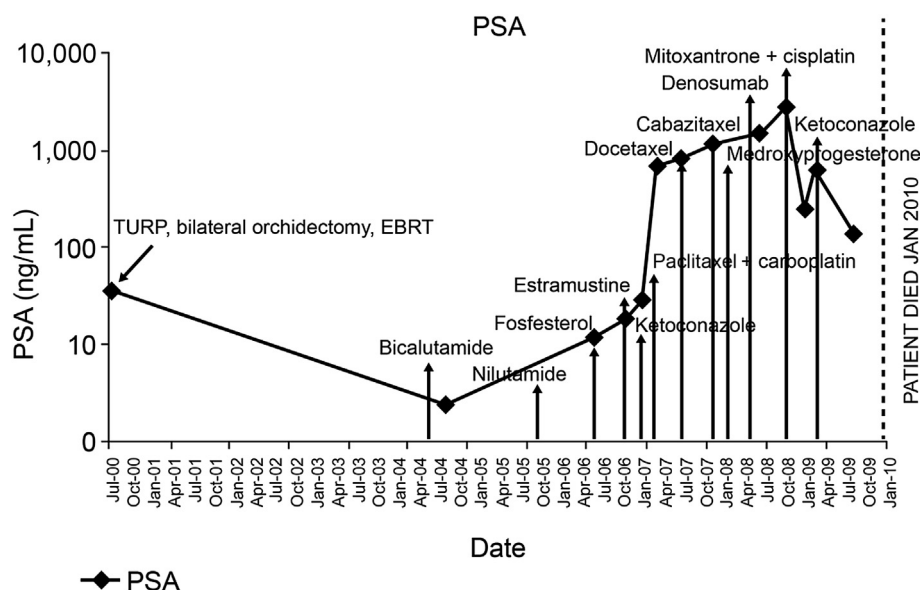


Fig. 1. Treatment history and disease progression of patient

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than 50% reduction in plasma PSA levels, while in Ferro et al,⁴ 13 out of 29 patients on oestrogen had more than 50% reduction in plasma PSA. A study by Orlando et al reported that low dose oral oestrogen improved outcome in patients who became refractory to chemical / surgical orchiectomy and anti-androgen.⁵ In one phase III trial, 27% of patients on anti-androgen withdrawal and ketoconazole had a PSA response compared to 11% of patients on anti-androgen withdrawal only.⁶ For estramustine phosphate, 35% of patients with advanced carcinoma of the prostate had an objective remission. A specific cytostatic effect of estramustine phosphate, may be responsible for remissions in some patients who have become resistant to conventional hormonal treatment. This cytostatic effect, however, is not clearly understood. Common adverse effects associated with ketoconazole include nausea, dry skin, and fatigue. Patients on oestrogen therapy may experience cardiovascular toxicity and thromboembolism.

In recent years, novel agents (such as abiraterone and enzalutamide) together with chemotherapy have changed the treatment approach for CRPC.^{7,8} This means that patients with advanced prostate cancer can expect improved quality of life, prolonged remissions and increased survival.

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